etc. which is described by a number of witnesses as different makes, models, colors but, for very good reasons, not by the license number. The British and most European countries have larger and more legible plates which readily afford instant identification. I can well imagine the anguish of manufacturers and state agencies if larger and more legible license plates were made obligatory but this would accomplish a great deal for driver responsibility and law enforcement and would probably be welcomed by the local police and highway patrol.

EDWARD B. SHAW, M.D.
Department of Pediatrics
University of California, San Francisco

It's Blood—Not Soup

To the Editor: "If we can impose strict liability upon a restaurant serving contaminated soup, certainly we can impose a similar standard on hospitals dispensing blood."

I am sure that Assemblyman Sieroty (D, Beverly Hills) has good intentions with his transfusion bill (AB 285). However, to equate blood with contaminated soup, or even borsht, is unreasonable. The above-quoted statement from Mr. Sieroty's news release of 2 February indicates his lack of understanding of transfusion and hepatitis problems.

Mr. Sieroty is conservative with his statement, "Hundreds of persons yearly contract hepatitis as a result of transfusion of contaminated blood." In fact, there are over 30,000 *reported* cases of transfusion hepatitis with 5 to 10 percent mortality. The principal source of this hepatitis is commercial blood obtained from Skid Row donors.

Of course there is a need for research to improve detection and elimination of hepatitis virus, and to make transfusion safer. However, it is unjust to penalize hospitals and physicians for the present inadequacy of medical science.

It is suggested that Mr. Sieroty, other politicians and MDs visit the Skid Row blood collection centers. It is urged that the news media and legislators be contacted to abolish commercial, for-profit blood banking. This will be in accord with my CMA resolution (131-72), which was ably supported by Professor J. Garrott Allen of Stanford and approved by the CMA House of Delegates at the February 1972 session.

ALBERT FIELDS, M.D.
Los Angeles

Methadone is Controversial

To the Editor: The article and the editorial on the subject of methadone maintenance for opiate addicts which appeared in the February, 1972, edition of CALIFORNIA MEDICINE, neglect some very important facts and misrepresent others.

First, the article never mentions the basic rationale for methadone maintenance. The rationale for methadone maintenance is that it is supposed to reduce the number of robberies, burglaries, and other thefts that heroin addicts commit in order to get the money with which to purchase heroin. The rationale is that if methadone is supplied to opiate addicts through legitimate channels, then the addicts will not have to steal to secure the funds to purchase heroin, all of which is supplied through an illegal market at an enormous profit to the suppliers. Hence, methadone maintenance is an attempt at a medical solution to a criminal or social problem.

Thus, it follows that the success of methadone maintenance depends not upon the number of addicts that can be kept in methadone maintenance programs, but rather it depends upon whether this new form of supplying the opiate to the addict will actually result in a decrease in the amount of property stolen by addicts.

It is no medical achievement to supply an addict with a substance to further his addiction. However, it *would be* a great feat of social engineering if one could somehow lower the crime rate, but we have yet to see any sort of research project wherein there was some kind of scientific attempt to see whether methadone maintenance did indeed cut down on the amount of thefts committed.

Not too long ago, there was some improvement noted in the crime rate in Washington, D.C., and some were quick to attribute this to the instituting of methadone maintenance. It should also be noted that simultaneously with these developments was an expansion of the local police force from around 3,000 officers to around 5,000 officers.

Although there are some pharmacological advantages to one's being addicted to methadone as opposed to one's being addicted to heroin, these are pharmacological advantages only incidental, and it is the method of supplying the opiate which is the significant issue.

This whole issue becomes a *medical* problem only insofar as physicians are required by law to

prescribe such drugs as opiates. By substituting legally prescribed methadone for illegally obtained heroin, we are not "solving" any sort of "medical problem." We are only making legitimate an addiction to opiates.

Those who voice such great enthusiasm for methadone maintenance should periodically remind themselves that they are not "treating" addiction. They are merely regulating the source, supply, and content of the addicting substance.

Moreover, they might well ask themselves what effect the prospect of eventually getting on methadone maintenance (that is, the eventual prospect of a reliable, dependable, and legal supply of an opiate) has on that large, but unknown, number of young men who are experimenting with heroin and who may go either way; become addicts or abandon the use of heroin as risky and self-destructive. We already know that with these people, the more readily is it that heroin is available, the more likely is it that they will become addicted to it, rather than abandon the use of heroin. Would not the prospect of dependably available methadone have that same effect?

That is to say, is not the prospect of eventually getting methadone maintenance serving to encourage individuals to experiment with heroin rather than to discourage them from doing so?

YEHUDA SHERMAN, M.D.
Oakland

Rising Cost of PG Study

To the Editor: Postgraduate medical education, always desired, has now become mandatory. Some states already will cancel a physician's license if he fails to put in a certain number of hours of postgraduate study.

By sheer coincidence (or is it really?), the cost of postgraduate courses is shooting up. Not long ago most postgraduate course fees were between $10 and $20 per day. Now it is rare to find a course that costs less than $30 a day and $40 a day courses are not rare. A few even run up as high as $50 a day, or $250 a week. When you add to this the cost of travel, hotel bills, meals and possible loss of income, the cost of postgraduate education is indeed high.

I am aware that many postgraduate education activities are free, but also there is no denying that many of the most desirable courses are given by the medical schools, and they are showing an almost exponential rise in fees.

Doesn't it sound just a little bit like exploitation of a captive customer, the practicing physician?

C. A. DOMZ, M.D.
Santa Barbara

An Ethical Issue

To the Editor: I had the pleasure recently of reading the CMA NEWS and learning that by edict of the CMA Council I am, in a 24 hour period, converted from ethical to unethical. This, if I don't tell patients that I own an interest in a hospital and because of this they may go elsewhere.

No one has bothered to ask why many physicians have elected to invest in hospitals. There are matters of the convenience of having all of your patients in one location—a time saver; the ability to exert your influence to insure efficiency in both cost and wasted time. For profit, hospitals must excel here to remain in business. The knowledge that if we are forced into a hospital dominated type of practice, as contemplated by Ameriplan and the insurance companies, then those of us practicing in a hospital environment with our "peers" in control may rest easier at night. In the past some of our colleagues have occupied the position of the chosen few in so far as the availability of hospital beds and this has led to ownership self preservation insuring beds for our patients. Surveys have shown that hospitals ranging in size from 99 to 150 beds are more economical, and many of us feel they offer more personalized service to our patients.

I do tell my patients that I go to specific hospitals for my convenience. I could site specific instances of problems that have arisen in the past causing me to take this action. I do not believe such would be in the best interest of either the hospital or the medical profession. As long as the hospital I send my patients to offers services as good as or better than other hospitals in the community in the field I practice in, I shall not specifically post a sign asking for prolonged discussion stating that I invested my hard earned money in the hospital I patronize so I can deliver better health care to my patients.

R. G. REAVES, M.D.
Santa Ana